MARYLAND HEALTH QUALITY AND COST COUNCIL

Meeting Minutes
Friday, September 19, 2014

Members in Attendance: Secretary Joshua Sharfstein (Vice Chair), James Chesley, Richard Davis, Barbara Epke, Nikki Highsmith Vernick, Roger Merrill, Jon Shematek, and Kathleen White

Members Absent: Lieutenant Governor Anthony Brown (Chair), Peggy O'Kane, Marcos Pesquera, Albert Reece, and Christine Wray

Welcome and Approval of Minutes

Secretary Sharfstein called the meeting to order at 9:36am. He welcomed the Council members and guests to the meeting. Minutes from the June 13, 2014 Council meeting were approved.

Health Enterprise Zone Update

Michelle Spencer, Director, Prevention and Health Promotion Administration, DHMH, and Mark Luckner , Executive Director of the Maryland Community Health Resources Commission (CHRC), provided the update on the Health Enterprise Zone project.

Ms. Spencer and Mr. Luckner began with an update on the successes and challenges faced by the Zones during Year One. All of the Zones have expanded provider capacity with 11 new or expanded delivery sites and 103 FTE staff added to the zones. After reviewing the challenges faced by the Zones in Year One, they provided an overview of the technical assistance the Zones will receive in Year Two. They will work with the Zones to collect and report clinical outcomes data, the external evaluator will begin to provide analysis beginning October 2, 2014, and they will create an HEZ Learning Collaborative to share information across the Zones. There will also be additional technical assistance provided.

Ms. Spencer and Mr. Luckner also provided an update on the Dashboard, which was developed to assess performance on key milestones, deliverables, and overall progress. The Dashboard is current under revision. Finally, Ms. Spencer and Mr. Luckner provided updates on cultural competency trainings and use of incentives authorized in the Health Enterprise Zone legislation.

Value Based Insurance Design (VBID) Task Force

Sara Cherico-Hsii, Health Policy Analyst-Advanced at DHMH, provided an update on the VBID Task Force.

After reviewing background information on the formation of the Task Force, Ms. Cherico-Hsii reviewed the differences between the original definition proposed by the VBID Task Force and presented to the Council in June 2014, as well as the revisions made by the Council in the June 2014 meeting. She then reviewed the public comments received during the 30 day comment period from August to September 2014.

Dr. Sharfstein led the Council in a discussion over public comments (see Appendix A). The Council made further revisions to the VBID definition and agreed this represents the first iteration of a VBID definition, and there is room to expand the definition in the future. The Council also agreed to send a letter to the Maryland Health Benefit Exchange Board encouraging them to incorporate VBID into plans offered on the Maryland Health Benefit Exchange beginning in calendar year 2016 and beyond, and include the revised definition. Dr. Roger Merrill agreed to present on behalf of the Council at the November 12, 2014 Maryland Health Benefit Exchange Board meeting.

Cheryl Boyer, Vice President of Human Resources at LifeBridge Health then provided an overview of the LiveWell@LifeBridge program for employees. She reviewed the formation of the program as well as outcomes, and outlined the future of the program in 2015 and beyond, including looking in on a non-smoking hiring ban for new employees.

Wellness and Prevention Workgroup Update

Dr. Donald Shell, Director, Cancer and Chronic Disease Bureau, Prevention and Health Promotion Administration, DHMH, provided an update on the Wellness and Prevention Workgroup.

Dr. Shell reviewed the work being undertaken in the Workgroup's four priority areas: clinical focus, community-clinical linkages, schools/communities, and worksites.

Telemedicine Task Force

Dr. David Sharp and Dr. Neal Reynolds of the Maryland Health Care Commission provided an update on the Telemedicine Task Force.

After reviewing the landscape of telehealth, Dr. Sharp and Dr. Reynolds summarized the finding of the three workgroups.

- The Clinical Advisory Group developed a set of use cases (pilot projects) proposed to accelerate telehealth diffusion in Maryland. The group proposed that the General Assembly consider providing approximately $1 million in funding for the implementation of select telehealth use cases.

- The Finance and Business Model Advisory Group identified key financial and business model challenges of deploying use cases and concluded that statewide policy current inhibit innovation in deployment of the use cases.

- The Technology Solutions and Standards Advisory Group determined that use cases could be implemented with current and evolving telehealth technology and recommended the development of a telehealth directory.

Pending funding approval, the use cases could begin implementation in FY 2016. In response to a question, Dr. Sharp and Dr. Reynolds clarified that phone calls and emails do not suffice and telehealth, which is limited to a combination of audio/visual.

All Payer Waiver
Secretary Sharfstein provided a brief overview of the new all-payer model for hospital payment, which was approved effective January 1, 2014.

Adverse Event Public Reporting
Ben Steffen, Executive Director, Maryland Health Care Commission (MHCC), presented on the status of adverse event public reporting in Maryland. He opened with a review of Maryland's approach to monitoring adverse events by the Office of Health Care Quality (OHCQ), MHCC, the Health Services Cost Review Commission, and the Maryland Patient Safety Center. Despite Maryland's comprehensive approach, gaps in oversight exist. For example, variation exist in adverse reporting for surgical services where only hospitals are subject to adverse event reporting to OHCQ, but the majority of surgeries take place in outpatient settings. Mr. Steffen also reviewed some success stories from public reporting.

Mr. Steffen closed by offering a formula for reducing adverse events, which includes:
- Comprehensive across all sites of service
- Accurate reporting confirmed through external review
- Aligned with broader quality and financial incentives
    - Ensure the organizations subject to reporting have incentives to improve
    - Agencies with responsibilities closely collaborate
- Actionable to providers
- Accessible to the public:
    - Will require a change in statutory authority.

The Council agreed that there is much to be done in this space and this seems like a good step forward.

Adjournment

The meeting was adjourned at 12:05 pm.

Appendix A. Council Response to VBID Public Comments

The Council posted its definition for public comment to the DHMH main webpage and pushed it out to stakeholders. The public comment period lasted 30 days and 10 comments were received: 5 from health plans and health systems; 2 from consumer groups; 2 from lobbying firm and consulting group; and 1 from a large employer.

The Council bucketed the comments for ease of discussion.

Minor Changes Proposed in Comments

The Council accepted most the minor changes proposed by commenters, including:

- The Council will not limit professional support to Choosing Wisely.
- The Council will include examples of tools to include cost-sharing, copayments and deductible exemptions in the opening paragraphs of the VBID definition.
- The Council will better define incentive and disincentive and clearly define an incentive for use of high-value service as "reduced or no cost sharing" in the opening paragraphs of the VBID definition.

The Council did not accept changing the number of health and wellness incentives back to two, but left at three.

Major Changes Proposed in Comments

The Council's responses to the major changes proposed by commenters include:

- The Council rejected the comment to remove the requirement for disincentives to be designated as a VBID plan. They felt it was critical to the success of the plans and shown in the literature to reduce costs.
- The Council clarified that services are related to medical conditions, and should have an impact on disease.
- The Council liked the idea of using available evidence to determine and list low and high value services, but felt that evidence-based medicine is still evolving, and this should be done in the future.
- The Council rejected the comment to remove the health and wellness component from the definition, because it plays an important role in health plans.
- The Council liked the idea of requiring patients to be active participants in their care and requiring financial incentives for consumers to choose high-quality and cost-effective physicians, but felt this did not belong in the first iteration of the definition, and could be considered at a later time.

Process Improvements Proposed in Comments

The Council agreed with the comments relating to the process improvements, including:

- When the Task Force reforms, they will invite consumer and safety-net stakeholders to participate and develop a list serve for those interested in receiving information.
- The Task Force should continue to educate the public, providers, and plans on VBID.
- VBID plans should educate their members on their health and health plans, focusing on quality and cost-effectiveness.

- The Task Force should clearly define the research that went into the creation of the definition.

Other Comments

The Council responses to other comments proposed by commenters include:

- The Council liked the idea of incentivizing consumers to choose high quality plans/providers, but felt this did not belong in the first iteration of the definition, and could be considered at a later time.
- The Council agreed that the physician-patient relationship is an essential factor in determining an appropriate care plan, but that VBID does not interfere with this relationship.
- The Council agreed that clinical procedures and services are constantly evolving as new standards of care are established and practice parameters are development. The Council felt that the definition represents the first iteration of VBID, and VBID has the potential to evolve as the clinical landscape evolves.
- The Council decided to write a letter to the Maryland Health Benefit Exchange Board to begin conversations about overseeing VBID implementation and certification in Maryland.